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Managing Census Variability

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A healthcare delivery system with 100% efficiency would have all patients with the same diagnosis at the same severity, all patients arrive and leave at the same time intervals, and all providers of health care (physicians, nurses) equal in their ability to provide quality care. In the real world of healthcare, patients and healthcare providers are much more variable than this idea. In recent years, the variability in patient census coupled with declining availability of healthcare providers has resulted in internal competition for staffed beds. ERs and ORs scramble to get their patients into inpatient beds. The fluctuation in patient population, scarcity of providers, and internal competition is most evident in the following four problem areas: 1) Emergency Department Diversions; 2) Nurse Under-staffing /Overload; 3) Medical Errors (Safety); 4) Health care costs.

Emergency Department diversions and nurse under staffing I overload have been attributed to a mismatch between patient demand and healthcare system capacity. The third and fourth issues; medical errors and healthcare costs have also been attributed, at least in part, to staffing issues. All four of these issues are partially driven by variation in the system. The management of variability is a primary challenge in healthcare delivery; therefore it should be identified, classified, measured and managed. Eugene Litvak, PhD, Director of the Program for Management of Variability in Health Care Delivery (http:11 management.bu.edu/research hcmrc/mvp/index.asp) at Boston University Health Policy Institute and his colleagues are working on this very issue.

They have identified two types of variability-natural and artificial. Natural variability includes such things as patient clinical disease severity, flow variability in admissions and discharges, and professional staff skill and knowledge differences. Natural variability stressors cannot be eliminated but should be carefully managed. In contrast, artificial variability , which includes non-random events such as elective admissions must be identified and eliminated. Often artificial variability is driven physician practices.

By understanding the difference between natural and artificial variability, "practical" applications to managing staffing challenges emerge:

1. Canceling scheduled surgeries during ED diversion
2. Capping admissions to hospital units
3. Smoothing scheduled surgical case volume through separation of surgical and emergency room beds
4. Dedicate one OR room for all "add-on" unscheduled procedures. The outcome in one hospital increased the number of surgical cases by 5.1% during the prime time hours(7:30 a-1 :30 p).

These strategies result in smoothing elective case volume. Success in smoothing elective case volume requires administrative leadership, physical cooperation and good operational data about outcomes. However, benefits identified in eliminating artificial variables are: 1) better utilization of resources, 2) reduced hours of emergency diversions, 3) increased staff and patient satisfaction, 4) reduced length of stay and 5) increased surgical throughput and revenue.

References:

1. Litvak E. & Lonq MC. Cost and Qualitv Under Managed Care: Irreconcilable Differences? American Journal of Managed Care. 2000: 6 (3): 305-312. http://www.aim.com/mar2000 litvak.html

2. Litvak E, Long MC, Cooper AB, McManus ML. Emergency Department Diversion: Causes and Solutions. Academic Emergency Medicine, November 20011 8 No 11 I pp.11 08-1110. http://management.bu.edu/pdf/litvak pdfs/ER divrs.pdf

3. Litvak E, McManus ML, Cooper AB. Root cause analysis of emergency department crowding and ambulance diversion in Massachusetts http://www.state.ma.us/dph/ dhcq/pdfs/FinalReporExecSum

30 minutes a Day

Whether physical activity reduces stroke risk remains controversial. The researchers used a meta-analysis to examine the overall association between physical activity or cardio-respiratory fitness and stroke incidence or mortality. The meta-analysis documented a reduction in stroke risk for active or fit individuals compared with inactive or unfit persons in cohort, case-control, and both study types combined.

For cohort studies, highly active individuals had a 25% lower risk of stroke incidence or mortality compared with low-active individuals. For case-control studies, highly active individuals had a 64% lower risk of stroke incidence than their low-active counterparts. When we combined both the cohort and case-control studies, highly active individuals had a 27% lower risk of stroke incidence or mortality than did low-active individuals. We observed similar results in moderately active individuals compared with inactive persons .

Conclusion:Even small amounts of exercise could reduce your risk of stroke significantly. Even though highly active people have the lowest risk of stroke, 30 minutes daily dramatically reduces risks

Source: Lee, C. D., Folsom, A. R., Blair, S. N.(2003) 'Physical activity and stroke risk: a meta-analysis,' Stroke 2003 Oct;34(10):2475-2481.

There's No "I" in Team, But There is One in Meeting*

In 1995, New York writer, Daniel Goleman published his groundbreaking book, Emotional Intelligence, spawning an industry devoted to measuring, explaining and training managers and the managed in the science of emotional intelligence (EI). Despite its popular appeal, EI is rooted in the concept of "social intelligence," first identified by E.L. Thorndike in 1920. Since that time, psychologists have been uncovering and grouping other intelligences, primarily into three clusters: 1. Abstract intelligence, the ability to understand and manipulate with verbal and mathematic symbols, 2. Concrete intelligence, the ability to understand and manipulate with objects and 3.Social intelligence, the ability to understand and relate to people.

Emotional intelligence, on the other hand, is a type of social intelligence that involves the ability to monitor one's own and others' emotions, to discriminate among them, and to use the information to guide one's thinking and actions. It involves five domains: Self-awareness, Managing emotions, Motivating oneself, Empathy, and Handling relationships.

Middle managers function in three types of groups, with three types of emotional dynamics: Groups they manage, where they set the emotional tone and the emotional rules; Peer groups, where they are among equals. Much of the behavior is focused on display and norms fluctuate constantly. With peers, the middle manager is not an emotional leader, but an emotional influencer; and Groups where they are managed, in which a boss or superior influences the emotional norms. The manager and his/her group share either allegiance or disdain for the leader. The emotional dynamics of these three types of groups are most evident in meetings. Manipulating group emotional dynamics, therefore, can have a decided effect on meeting outcomes. But to use EI to influence the group in a meeting, one must first gauge both his/her individual emotional intelligence and that of other members of the group. This is one reason why meeting are a challenge!

* abstracted from Roy L Simpson, "There is no I in Team" *Seminars in Nursing Management,* Spring 2001.

A line from "What the Books Don't Tell You about Leadership"

"Don't let your assets become your liabilities !"

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